



*Testimony before the Human Services Committee
Roderick L. Bremby, Commissioner
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Good morning, Senator Slossberg, Representative Abercrombie and distinguished members of the Human Services Committee. My name is Roderick Bremby and I am the Commissioner of the Department of Social Services. I am pleased to be before you today to testify on two bills raised on behalf of the Department. In addition, I offer written remarks on several other bills on today's agenda that impact the Department.

Bills Raised on Behalf of DSS:

S.B. No. 406 (RAISED) AN ACT CONCERNING CERTIFICATES OF NEED FOR NURSING HOMES

The proposed legislation deletes obsolete provisions, makes technical changes to the department's Certificate of Need (CON) statutes, and arranges the statutes in a more logical and cohesive format. The proposal also removes the requirement for a CON for transfers of ownership and acquisition of imaging equipment. These proposed legislative changes are requested, in part, to support the Money Follows the Person rebalancing initiative which provides nursing home residents the ability to receive services in a community setting.

The proposed section 17b-352 delineates all of the activities that require CON approval, maintains the moratorium on additional nursing home beds through June 30, 2016, provides correct statutory references, and removes outdated references to the Office of Health Care Access (OHCA). This bill also includes a provision to allow the Department, based on regional service needs, the flexibility to establish a nursing home bed pilot up to 35 beds, if necessary. The former subsections in section 17b-354 with respect to continuing care facilities have been deleted as continuing care facilities are addressed in Chapter 319hh. Some of the language removed from section 17b-354 is included in a new proposed section. Specifically, the moratorium language in section 17b-354 was moved to the proposed section 17b-352 as this language is incongruously placed where it is currently located. In addition, the department proposes to keep the language concerning the acceptance of nonresidents as nursing facility patients to continuing care facilities on a contractual basis and the same requirements. The department proposes to move this language to a new section in Chapter 319hh. Rather than addressing a "continuing care facility which guarantees life care for its residents," the proposed moratorium language references continuing care facilities that are registered as continuing care facilities pursuant to Chapter 319hh. This provision would be triggered only in the event of a significant shortage of nursing home beds in a specific locality within the state. The department has also proposed some technical changes in Chapter 319hh which are not substantive in nature.

The guidelines utilized in evaluating a CON proposal were moved from section 17b-355 to the proposed section 17b-353 and have been revised to remove irrelevant criteria. Requirements with respect to the application and hearing process have been consolidated into the proposed section 17b-354. The proposed section 17b-354 changes some of the requirements for a hearing and allows for expedited review in certain types of CON applications. The department also proposes an expedited review process for the closure or reduction of beds in a residential care home as this is not a medical facility, the average number of licensed beds is approximately 15 to 20 beds and, often, a resident is eligible for community-based programs that may be available in the area.

The department further proposes to remove the requirement for a public hearing when the closure is attributable to occupancy of less than 75% because once census has decreased below this level, it becomes difficult for the facility to remain financially viable and may lead to health and safety concerns impacting residents. Also, a rapid decline in census indicates there are beds available for the residents in the service area.

The proposed section 17b-354a establishes the time period for which a CON is valid, the process for requesting an extension of a CON, requirements for demonstrating that construction has begun and the department's ability to withdraw, revoke or rescind the CON.

The proposed changes to sections 17b-354b and 17b-354c are primarily technical in nature and remove obsolete provisions. Judicial enforcement language has been moved from section 17b-354a to section 17b-355.

Upon review of the raised bill, the department has identified a technical correction, which is appended to my written remarks for your consideration.

We ask for your support of this bill.

S.B. No. 410 (RAISED) AN ACT CONCERNING ADMINISTRATIVE HEARINGS CONDUCTED BY THE DEPARTMENT OF SOCIAL SERVICES

This bill updates DSS fair hearings procedures for clarity, efficiency, and consistency with federal law. Moreover, several of the changes being proposed will ease the burden on clients by allowing additional methods by which they may request hearings and greater flexibility in when they are required to attend.

Specifically the bill proposes the following:

Section 1 expands the ways that client hearings may be requested to include by mail, phone or other electronic means as contemplated under the Affordable Care Act (ACA). It specifies who may request a hearing on behalf of a client. Under current law, a request for a hearing must be mailed to the Commissioner within sixty days after the date of the decision being contested. In order to accommodate an anticipated change in our eligibility management system without affecting clients, this proposal provides that a hearing request must be received by the Department within sixty-five days of the date of the decision. This proposal increases the number

of days within which DSS must schedule a hearing from 30 to 45 and limits to three the number of continuances that may be granted. The proposal also provides that a client need not be present if represented by legal counsel and if not needed to testify. Lastly, the proposal allows testimony by phone in the hearing officer's discretion.

Section 2 makes clarifications that are not substantive changes to practice.

Section 3 specifies that the decisions that may be contested under the section are those that involve the issuance of a payment rate to a provider and deletes some obsolete language.

We ask for your support of this bill.

Other Legislation Impacting the Department:

S.B. No. 321 (RAISED) AN ACT CONCERNING MEDICAID COST SAVINGS

This bill would create a task force charged with reviewing best practices concerning Medicaid cost savings. The department has no objections to working with our partners to identify additional cost savings that may be achieved within the Medicaid program.

S.B. No. 326 (RAISED) AN ACT CONCERNING FEDERAL MEDICAID WAIVERS

This bill directs the Department to conduct a study to determine the need for additional Medicaid waivers or changes to the existing Medicaid waivers administered by DSS. The department is constantly striving to improve our programs that serve the residents of Connecticut and we therefore have no objections to this proposal.

S.B. No. 327 (RAISED) AN ACT CONCERNING NURSING HOMES & S.B. No. 329 (RAISED) AN ACT CONCERNING LONG-TERM CARE

The Department of Social Services commends the Committee for its attention to the need for strategic planning for Medicaid long-term care services. This is a critical need given the strong preferences of older adults and individuals with disabilities to live in home and community-based settings, the state's interest in controlling escalating costs, and support for town-level tailoring of strategies to meet local needs. DSS respectfully suggests to the Committee, however, that the studies that are being proposed by S.B. 327 and S.B. 329 are not needed. In keeping with the legislation enacted by the General Assembly, Governor Malloy, the Office of Policy and Management, and DSS released the Strategic Plan to Rebalance Long-Term Services and Supports, which already captures the data and planning strategies that are contemplated by these bills.

In support of the RFP for nursing facility diversification, the Department contracted with Mercer to make town-level projections of need for nursing home beds and associated workforce for all cities and towns in Connecticut. This was released in 2013, and Mercer is currently updating the projections.

The Plan can be accessed at www.ct.gov/dss/rebal.

S.B. No. 408 (RAISED) AN ACT CONCERNING MENTAL HEALTH OPTIONS FOR ADULT MEDICAID RECIPIENTS

This bill would allow Medicaid eligible members who are over the age of 21 to see an independent licensed psychologist. Currently this is not allowable in our state plan and would have to be added as a new service. There are no funds included in the Governor's recommended budget adjustments to support this addition; therefore, the department must oppose it at this time.

H.B. No. 5445 (RAISED) AN ACT CONCERNING MEDICAID COVERAGE OF TELEMONITORING SERVICES

This proposal requires the Department to add telemonitoring services to the Medicaid State Plan as an optional service. The department is currently working with UConn on developing a pilot program to implement telemedicine on a limited basis. There are no funds included in the Governor's recommended budget adjustments to support this addition; therefore, the department must oppose it at this time.

H.B. No. 5447 (RAISED) AN ACT CONCERNING RATES OF REIMBURSEMENT FOR EMERGENCY AMBULANCE TRANSPORTATION FEES PAID BY THE DEPARTMENT OF SOCIAL SERVICES

This proposal requires the Department to provide an increase to the emergency ambulance transportation provider rate. There are no funds included in the Governor's recommended budget adjustments to support this addition; therefore, the department must oppose it at this time.

S.B. No. 407 (RAISED) AN ACT CONCERNING A HOSPITAL QUALITY OF CARE INITIATIVE

The Department offers below:

- its position on Raised Senate Bill 407; and
- related background information on Connecticut Medicaid care coordination and primary care initiatives.

Position on Raised Senate Bill 407

Raised Senate Bill 407 seeks to 1) establish a Medicaid pay-for-performance initiative under which hospitals that perform on a range of identified measures related to care coordination of Medicaid beneficiaries will be eligible for supplemental Medicaid payments; 2) create a dedicated account in which Medicaid funds will be reserved for purposes of making performance

payments; and 3) require DSS to annually update hospital payment rates by utilizing the inpatient prospective payment system hospital market basket.

DSS acknowledges that the bill reflects collaborative conceptual discussions among the Department, its contractor CHN (the Administrative Services Organization [ASO] for Medicaid and CHIP medical services), and the Connecticut Hospital Association (CHA) around applied collaborative efforts in support of reducing unnecessary use of emergency departments and hospital admissions, as well as intercepting the rate of hospital readmission. This is intended to supplement the current work of the medical and behavioral health ASOs through their existing Intensive Care Management (ICM) initiatives, which are already yielding notable improvement on these indicators. Notwithstanding, the Department has the following concerns about the bill as it is currently framed:

- **Concerning the proposed “Supplemental HCCP payment pool account”:** The bill proposes to establish a separate, nonlapsing account within the Department of Social Services and to fund it annually in the amount of three per cent of the amount paid to hospitals. Three percent of the amount paid to hospitals in SFY 2013 equals \$50 million. Additionally, utilizing the inpatient prospective payment system hospital market basket estimated at 2.7% would cost an additional \$20 million annually. The Department cannot support these proposals as these funds are not included in the Governor’s budget.
- **Concerning the proposed model of coordination:** Discussion among the CHA, the Department and CHN has been ongoing at the same time that the State Innovation Model (SIM) process has moved forward. As you are aware, SIM is a broad, multi-payer effort that has engaged diverse stakeholders in support of “establish[ing] primary care as the foundation of care delivery that is consumer and family centered, team based, evidence driven and coordinated, and in which value is rewarded over volume.” Very notably, two key aspects of the SIM care delivery reforms are to reinvest health care savings in:
 - an Advanced Medical Home model that will allow practices to manage effectively the total needs of a population of patients; and
 - Designated Prevention Service Centers (“Prevention Service Centers”) and Health Enhancement Communities (HECs), which will coordinate the efforts of community organizations, healthcare providers, employers, consumers and local public health entities.

While there is no doubt that hospitals will continue to play an essential role in the continuum of health care services, the SIM model’s emphasis, with respect to investment of savings, is on primary care and population health organizations. Since the SIM demonstration period, which will span from SFY’16 through SFY’20, will overlap with the period proposed for the activities proposed by the bill, it will be necessary to carefully align vision and strategies between the two to ensure consistency of purpose.

Ideally, aligning this initiative and SIM will focus on two elements:

- building means of rewarding value on the basis of identified metrics into a modernized hospital payment scheme, on which the Department and Mercer are currently working; and
 - selecting measures of performance in partnership with the SIM Quality Council that are consistent with, and further SIM goals.
- **Concerning the terms of collaboration between the hospitals and CHN:** Even in the absence of a near-term pay-for-performance initiative, it would benefit Medicaid beneficiaries to enhance the means of collaboration between hospitals and CHN, and to track and measure the outcomes of such collaboration. While the Department strongly supports the bill's orientation to use of measures, we have the following concerns:
 - The bill as framed seeks to authorize the Department and CHA to negotiate and agree upon the terms of 1) the content and frequency of performance reporting; and 2) the form and frequency of meetings to discuss and share best practices on implementing the requirements of the quality of care program. The bill does not require common development of the quality measures on which the hospitals will be assessed for purposes of any future performance payments. This should be reflected in the bill language. While the bill as framed proposes specific quality measures, the Department believes that it would best serve the interest of Medicaid beneficiaries to use Medicaid data to identify measures, both in the near term, and on an evolving basis as needs may change. An applied example of an area in which a measure would be valuable relates to better supporting individuals who are presenting to hospital emergency departments because of unresolved pain.
- Further, selection of measures should be made in coordination with SIM. The Department's preferred means of ensuring this is to select measures in conjunction with the SIM Quality Council, which will be launched in April. This intent should be reflected in the bill.
- The bill as framed takes a permissive approach to the requirements for hospitals' receipt of performance payments.
 - Sub-section (c) proposes, in year one of the initiative (SFY' 15) to permit hospitals to earn performance payments for participating in 1) the inpatient discharge care management program; 2) the intensive case management

- program; or 3) a program to stabilize or reduce all-cause readmission rates.
- sub-section (d) proposes, in years two and three of the initiative (SFY's 16 and 17) to permit hospitals to earn performance payments for participating in 1) the inpatient discharge care management program; 2) the intensive care management program or programs to stabilize or reduce (3) all-cause readmissions; (4) COPD admissions; (5) chronic heart failure admissions; or (6) adult asthma admissions.

As DSS understands the language of the bill, the "inpatient discharge care management program" will permit CHN to embed members of its ICM staff on site in hospitals to collaborate on and support effective discharges of hospitalized individuals to the community. Further, DSS understands the bill to indicate that the "intensive care management program" will permit hospitals to work with members of the CHN ICM staff to support individuals post-discharge, with an emphasis on those who have had two or more readmissions to the hospital within thirty days of discharge, or repeated history of leaving the hospital against medical advice.

The Department urges that both of these, as opposed to one of the two, be required as threshold qualifications for hospitals to qualify for performance payments. This activity is already ongoing with two Connecticut hospitals, and the benefits with respect to improved communication and coordination on behalf of mutual clients have been evident. Notably, these relationships have developed successfully absent of financial incentive, and CHN is actively soliciting participation by additional hospitals.

Further, the Department has proposed to CHA that another process measure – sharing real-time data on use of emergency department by Medicaid beneficiaries with CHN - be incorporated as a requirement for receipt of any future performance payments. This is not referenced in the bill.

- **Concerning the requested "market basket" update:** While Connecticut regulations provide for an annual inflationary increase for hospitals under C.G.S.A. Section 17b-312-104, the Legislature historically has not authorized inpatient hospital inflationary increases on a regular basis. In light of the anticipated implementation of DRGs and ongoing state fiscal constraints, DSS' position is that it would be difficult for the State of Connecticut to commit to fund automatic and ongoing inflationary increases at this time. The Department also questions the utilization of a "Medicare Market Basket" as an inflator because CMS does not issue a "Medicare Market Basket". Instead, CMS produces individual market baskets specifically for CMS payment systems to accurately measure "pure" pricing changes. These are subject to additional adjustments within their system and do not reflect a comprehensive inflationary indicator.

Background on Connecticut Medicaid Care Coordination and Primary Care Initiatives:

Three key features of Connecticut Medicaid’s care delivery reform are:

- use of “predictive modeling” tools to identify members in greatest need of support;
- use of Intensive Care Management (ICM) to assess the needs of members, and then with members to develop person-centered plans of care that are aligned with members’ goals; and
- development of the primary care network to better equip PCPs to anticipate and to respond to the needs of their patients.

These initiatives are achieving results. Notably:

- outcomes for individuals served by the CHN ICM program between January 1, 2012 and October 31, 2012 (this period permits comparison of claim data six months pre- and six months post-ICM engagement) include:
 - a 43.17% reduction in inpatient admissions
 - a 6.14% reduction in use of the emergency department
- outcomes for individuals served by the ValueOptions ICM program include:
 - a 72.7% reduction in total days in a confined setting
 - a 73.5% reduction in psych days
 - a 69.2% reduction in inpatient detoxification days
 - a 10.5% increase in total days in the community
- enrollment of PCPs in Medicaid has been increasing:

Specialty Code	2012-01	2013-01	2013-12
APRN	235	391	578
PHYSICIAN	1362	1826	2442
PA	25	153	236
Grand Total	1,622	2,370	3,256

- participation of both members and providers in the Department’s Person-Centered Medical Home (PCMH) initiative is increasing – currently over one-third of all Medicaid beneficiaries is being served by a PCMH – and health and client satisfaction outcomes of members served by PCMH are overall better than those served by non-PCMH practices.

Predictive Modeling and ICM: Both the medical and behavioral health (BH) ASOs (respectively, CHN-CT and Value Options) use predictive modeling to identify individuals in need of ICM. In

support of its ICM activity, CHN-CT has fully implemented a tailored, person-centered, goal oriented care coordination tool that includes assessment of critical presenting needs (e.g. food and housing security), culturally attuned conversation scripts as well as chronic disease management scripts. Additionally, CHN-CT now has in place geographically grouped teams of nurse care managers. CHN-CT and Value Options coordinate in supporting the needs of individuals with co-occurring medical and behavioral health conditions through a behavioral health unit staffed by credentialed individuals that is co-located with the medical ASO. Care managers from CHNCT, DSS and Value Options meet twice weekly to review hospitalizations and planned admissions to identify the appropriate care manager to take responsibility for the member's care. In cases where neither the physical or behavioral diagnosis is primary, both the CHN and the Value Options care manager remain involved. At any given time, approximately 500 members are receiving ICM because they are diagnosed with a Serious and Persistent Mental Illness (SPMI) in addition to a physical diagnosis.

Support for Primary Care Practices: The Department has also been able to use state and Affordable Care Act resources to provide significant new supports to PCPs. These supports include:

- **Primary Care “Rate Bump”:** Effective January 1, 2013, the Affordable Care Act (ACA) required states to increase Medicaid payments for identified services provided by primary care doctors to 100% of the Medicare payment rate for 2013 and 2014 (financed with 100% federal funding). Services must be delivered by a physician who specializes in family medicine, general internal medicine, or pediatric medicine; or practitioners (e.g. Advance Practice Registered Nurses, APRNs) working under the personal supervision of any qualifying physician. Certain physician subspecialists who are board certified in those specialties or provide primary care within the overall scope of those categories also qualified for the enhanced payment. DSS implemented Affordable Care Act (ACA) rate increases on July 1, 2013 for 2,277 approved providers who attested as to their eligibility. Beginning on July 1, 2013, approved providers began receiving enhanced payments. Providers also received payment for claims back to January 1, 2013, which were automatically identified and reprocessed by HP. In many cases, rates were increased more than 40%.
- **Person-Centered Medical Homes (PCMH).** The Department implemented its Person-Centered Medical Home (PCMH) initiative on January 1, 2012. The premise of a PCMH is that it enables primary care practitioners to bring a holistic, person-centered approach to supporting the needs of patients, while reducing barriers to access (e.g. limited office hours) that have inhibited people from effectively using such care. Through this effort, the Department is investing significant resources to help primary care practices obtain PCMH recognition from the National Committee for Quality Assurance (NCQA). Practices on the “glide path” toward recognition receive technical assistance from CHN-CT. Practices that have received recognition are eligible for financial incentives including enhanced fee-for-service payments and retrospective payments for

meeting benchmarks on identified quality measures; practices on the glide path receive prorated enhanced fee for service payments based upon their progress on the glide path but are not eligible for quality payments at this time . Key features of practice transformation include embedding limited medical care coordination functions within primary care practices, capacity for non-face-to-face and after hours support for patients, and use of interoperable electronic health records (EHR).

- **Electronic Health Records (EHR).** Another important aspect of enhancing the capacity of primary care is financial support for adoption of EHR. EHR support more person-centered care and reduce duplication of effort across providers. DSS is collaborating with UConn Health Center to administer a Medicaid EHR Incentive Program and to improve outreach and education to providers. Incentive payments disbursed from September, 2011 to January, 2013 include \$18,642,346 to 929 eligible professionals and \$22,268,898 to 25 eligible hospitals. “Eligible professionals” include physicians, physician assistants, nurse practitioners, certified nurse-midwives, and dentists.
- **Rewards to Quit.** This tobacco cessation initiative is being funded by a five-year federal grant of up to \$10 million. Through the program, providers (local mental health authorities, federally-qualified health centers and primary care practices) will offer counseling and training sessions, peer coaching and other smoking-cessation techniques. Participating beneficiaries will receive financial incentives for achieving various milestones toward quitting.

Thank you for the opportunity to testify on these bills today. My staff and I would be happy to answer any questions that you may have.